Patient Acknowledgement or Receipt
Of the
Notice of Privacy Practices

Highland Wellness Center
5606 Wilson Mills Rd.
Highland Heights, OH 44143

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

By signing this document, I acknowledge that you have a provided me with a copy of your *Notice or Privacy Practices*. The *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Date_____ Referred by _____

Cell phone _____

Name _____Home phone _____

Last *First* *Middle* Email_____

Address _____ City/ State/ Zip _____

DOB _____Sex _____ SS# _____ Marital Status M S D W

Contact Friend/ Relative _____ Phone _____

Address _____ City/ State/ Zip _____

Name of Employer _____

Address _____ City/ State/ Zip _____

Phone _____ Position _____

Spouse's Name _____ Phone _____

Name of Employer _____

Address _____ City/ State/ Zip _____

Phone _____ DOB _____

Primary Care Provider _____ Phone _____

PLEASE READ & SIGN

Failure to cancel appointments without 24-hour notice will result in full appointment fee.

If my insurance covers a portion or none of my medical bills incurred at this office, I understand that I am responsible for the balance due. If my insurance benefits have been utilized or utilized else where, I understand that I am responsible for all accruing charges.

Signature *Date*

I authorize release of any medical information necessary to process any insurance claims.

Signature *Date*

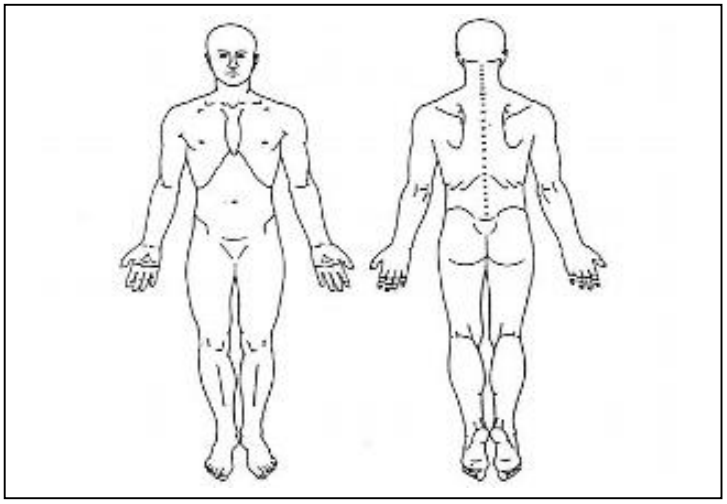
NAME_____DATE_____

	PROBLEM #1	PROBLEM #2
List and describe major problems in order of importance.		
When did it occur? Date?		
Accident related? Give details.		
What makes it better? (Medications, position, hot, cold, etc.)		
What makes it worse?		
Have you had this before? When?		
Have you seen another physician for this problem? Who?		
Were X-rays taken? Of what?		

Were you disabled from work? Y N Date last worked? _____Date Returned to work?_____

Please describe pain and location on the diagram.

Ache	Burn	Numbness	Pins & Needles	Stabbing	Other
XXX	ZZZ	OOO	. . .	/////	***



Place an "X" through the line indicating your current level of pain.

No Pain 0---1---2---3---4---5---6---7---8---9---10 Worst Possible Pain

NAME _____ Date _____

PERSONAL HISTORY

Mark the box with an X if it applies to you & circle the appropriate symptom. Explain all YES answers with dates (month & year).

Has any blood relative ever had:

- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Kidney Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Problems
- ☐ Cancer
- ☐ Hypoglycemia

Have you ever had problems with:

- ☐ Weight Change, gained or lost in past 5 years
- ☐ Fever, chills, sweats
- ☐ Allergy, Aslhma
- ☐ Anemia, Bleeding or bruising
- ☐ Thyroid Problems, Heat or cold intolerance
- ☐ Diabetes
- ☐ Eye problems (glasses, glaucoma etc.)
- ☐ Ear problems (ringing, deafness, ear infections)
- ☐ Nose/Throat problems (sinis, nosebleeds, hoarseness)
- ☐ Dizziness
- ☐ Jaw (TMJ) or dental problems
- ☐ Nausea or Vomiting
- ☐ Stomach Problems (ulcer, indigestion, heartburn, Hiatal hernia)
- ☐ Abdominal pain or swelling
- ☐ Diarrhea or constipation

How often do you have a bowel movement?

- ☐ Tarry black stool or blood in stool
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Liver or Gall Bladder problems
- ☐ Pancreas
- ☐ Do you drink alcohol?

How much?

- ☐ Shortness of breath, wheezing
- ☐ Lung problems (coughing, phlegm blood, infection, pneumonia) Tuberculosis?
- ☐ Do you smoke? How many years? How many packs?
- ☐ Occupational or Environmental Inhalation
- ☐ Heart problems
- ☐ Chest pain
- ☐ Palpitations in the heart
- ☐ High Blood Pressure
- ☐ Rheumatic fever

NAME _____ Date _____

- [ ] Urinary problems (Frequent, painful, or dribbling urination)
- [ ] Blood in Urine
- [ ] Bladder or Kidney problems
- [ ] Sexually transmitted diseases
- [ ] Testicle mass or pain
- [ ] Breast lump, pain or nipplc discharge

FOR FEMALES:

- [ ] Menstral problems
- [ ] Pelvic pain, vaginal discharge
- [ ] Ovarian cyst
- [ ] Menopause , At what age?

Menstrual flow: How many days? How many days between periods?
Date of last period
Date of last PAP?

- [ ] Skin itching or rash
- [ ] Skin Cancer
- [ ] Headaches
- [ ] Seizures
- [ ] Head trauma
- [ ] Stroke
- [ ] Joint pain, swelling or stiffness
- [ ] Neck Pain
- [ ] Upper back pain
- [ ] Low back pain
- [ ] Arm or leg problems
- [ ] Fractures, dislocations, or sprains
- [ ] Car accidents, falls or injuries
- [ ] Drug abuse
- [ ] Pyschiatric problems, anxiety, depression
- [ ] Shoe lift or insert
- [ ] Poor sleep quality. How many hours per night?

List all hospitalizations, surgeries, diseases with date:

List current medications & vitamins/supplements:

Financial Responsibility

Payment is due at the time of service unless prior arrangement has been made with our billing department.

- We accept cash, Visa, Mastercard, American Express or Discover.
- We will process your insurance forms upon receipt of your insurance card (copy).
- You will be responsible for meeting your deductibles, co-pays or costs of non-covered services at the time of visit.
- Returned checks and balances due over 30 days will be subject to collection fees and interest charges of **3.0% per month**.
- Your insurance is a contract between you, your employer and your insurance company.
- Our fees are considered usual, customary and reasonable. (UCR)
- Insurance coverage vary widely. We are participating providers for most insurance companies including Cigna, Aetna, Emerald, Medical Mutual, United Healthcare, Humana, PHCS and Medicare, we are not participating in any HMOs. Most insurance companies cover chiropractic, however deductibles and co-pays do vary.

Failure to cancel appointments without 24 hour notice will result in full appointment fee.

I have read and agree to the above terms.

Signature_____Date_____